

Mail / Fax to: Planned Administrators, Inc.
PO Box 6702
Columbia, SC 29260

Telephone (866) 798-0803
Fax (803) 264-0772

Underwritten by
BCS Insurance Company
Oakbrook Terrace, IL

Fill out this form ONLY if you are making changes in your coverage or terminating coverage.

A. REASON FOR THE CHANGE

Address Change Name Change Add Dependent(s) Coverage Change Terminate Coverage

B. REQUIRED EMPLOYEE INFORMATION

MUST BE FILLED OUT

Address/Name Change

Name	Social Security #	Phone	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
Address	City	State	Zip	Apt. #
Employer	Hire Date / /		Date of Birth / /	

Add/Change Dependent Information

Name	Social Security #	Date of Birth / /	Gender	Relationship
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

C. INDEMNITY PLAN CHANGES - Select the change you wish to make for each benefit

Payroll Deducted Rates

You **MUST** select a coverage level before adding any benefits in Section C. Your coverage level for the all benefits in Section C will be identical.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹			DENTAL			VISION			TERM LIFE			SHORT-TERM DISABILITY ²		
	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly
Employee Only <input type="checkbox"/>	\$19.96	\$39.92	\$43.25	\$6.17	\$12.34	\$13.37	\$1.67	\$3.33	\$3.61	\$0.60	\$1.20	\$1.30	\$4.20	\$8.40	\$9.10
Employee + 1 <input type="checkbox"/>	\$40.51	\$81.02	\$87.77	\$12.34	\$24.68	\$26.74	\$3.33	\$6.66	\$7.22	\$0.90	\$1.80	\$1.95	-	-	-
Employee + Family <input type="checkbox"/>	\$54.09	\$108.18	\$117.20	\$20.36	\$40.72	\$44.11	\$5.28	\$10.57	\$11.45	\$1.80	\$3.60	\$3.90	-	-	-
Terminate All Plans <input type="checkbox"/>	<input type="checkbox"/> Enroll			<input type="checkbox"/> Enroll			<input type="checkbox"/> Enroll			<input type="checkbox"/> Enroll			<input type="checkbox"/> Enroll		
No Change to Any Plan <input type="checkbox"/>	<input type="checkbox"/> Cancel			<input type="checkbox"/> Cancel			<input type="checkbox"/> Cancel			<input type="checkbox"/> Cancel			<input type="checkbox"/> Cancel		
	<input type="checkbox"/> No Change			<input type="checkbox"/> No Change			<input type="checkbox"/> No Change			<input type="checkbox"/> No Change			<input type="checkbox"/> No Change		

¹This coverage is not available to residents of NH, HI, or PR. ²STD is not available to persons who reside in CA, HI, NJ, NY, or RI.

Add/Change Life/Accidental Death & Dismemberment Beneficiary

Primary	Relationship
Secondary	Relationship

D. REQUIRED SIGNATURE

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings. I understand that deductions may continue under my old elections until this form is received and processed by PAI. Deductions will not be refunded. **I understand that making no selection in Section C for a benefit means I do not wish to make a change to that benefit.**

DATE ___/___/_____

► SIGNATURE